Margaret Martin, LCSW ● 4534 Westgate Blvd., Ste 112, Austin, Texas 78745 ● 512-423-8237

Authorization for Use or Disclosure of Protected Health Information

I, _____, _____, hereby authorize
client name date of birth

Margaret Martin, LCSW to release/disclose to:

_____ _____ _____
name relationship phone

any and all Protected Health Information (PHI) including mental health and medical records and/or information, psychotherapy notes and verbal communication, that Ms. Martin may have in her possession or subject to her control pertaining to my diagnosis and entire course of treatment with Ms. Martin.

Additionally, I authorize _____

to release/disclose any private information about me, including any and all PHI, mental health and medical records and/or information, psychotherapy notes and verbal communication, to Margaret Martin, LCSW.

This release of information is for the purpose of:

____ Treatment ____ Payment ____ Other: _____

I understand that I am waiving my right to confidentiality with respect to the records and information released pursuant to this consent and hereby release Ms. Martin from any and all liability arising from the release of the information. I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

This consent form will expire in 1 year, unless a request is received in writing altering the expiration date. I understand that I may rescind this consent in writing at any time.

_____ _____
client signature date